

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03064

3087

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>W. Charles</u> Middle <u>Blackburn</u> Last <u>Blackburn</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 8, 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Calvert Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Blackburn</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Dixon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Edward Blackburn, Lusby, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile Dementia -</u> 304X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decompenstation</u> DUE TO (c) <u>Malnutrition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>2 weeks</u> <u>4 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 2, 1959</u> , to <u>March 15, 1960</u> , that I last saw the deceased alive on <u>March 6, 1960</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Prince Frederick 3/16/60</u>	
PHYSICIAN'S NAME (Type) <u>Page C. Jett</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 18, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lusby, Calvert Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.G. Harkness, Jr., Mutual, Md.</u>		24. REC'D BY REGISTRAR <u>Mar 21 '60</u> DATE	
		25. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital. After the attending physician has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Nature of disease		9. Duration of illness		10. Place of residence		11. Occupation		12. Marital status	
13. Signature of physician		14. Signature of registrar		15. Signature of informant		16. Signature of witness		17. Signature of funeral director		18. Signature of undertaker	
19. Name of funeral home		20. Name of undertaker		21. Name of cemetery		22. Name of church		23. Name of school		24. Name of hospital	
25. Name of doctor		26. Name of nurse		27. Name of pharmacist		28. Name of dentist		29. Name of optician		30. Name of veterinarian	
31. Name of coroner		32. Name of justice of the peace		33. Name of sheriff		34. Name of clerk of the court		35. Name of judge		36. Name of mayor	
37. Name of city		38. Name of county		39. Name of state		40. Name of country		41. Name of continent		42. Name of world	
43. Name of city		44. Name of county		45. Name of state		46. Name of country		47. Name of continent		48. Name of world	
49. Name of city		50. Name of county		51. Name of state		52. Name of country		53. Name of continent		54. Name of world	
55. Name of city		56. Name of county		57. Name of state		58. Name of country		59. Name of continent		60. Name of world	
61. Name of city		62. Name of county		63. Name of state		64. Name of country		65. Name of continent		66. Name of world	
67. Name of city		68. Name of county		69. Name of state		70. Name of country		71. Name of continent		72. Name of world	
73. Name of city		74. Name of county		75. Name of state		76. Name of country		77. Name of continent		78. Name of world	
79. Name of city		80. Name of county		81. Name of state		82. Name of country		83. Name of continent		84. Name of world	
85. Name of city		86. Name of county		87. Name of state		88. Name of country		89. Name of continent		90. Name of world	
91. Name of city		92. Name of county		93. Name of state		94. Name of country		95. Name of continent		96. Name of world	
97. Name of city		98. Name of county		99. Name of state		100. Name of country		101. Name of continent		102. Name of world	
103. Name of city		104. Name of county		105. Name of state		106. Name of country		107. Name of continent		108. Name of world	
109. Name of city		110. Name of county		111. Name of state		112. Name of country		113. Name of continent		114. Name of world	
115. Name of city		116. Name of county		117. Name of state		118. Name of country		119. Name of continent		120. Name of world	
121. Name of city		122. Name of county		123. Name of state		124. Name of country		125. Name of continent		126. Name of world	
127. Name of city		128. Name of county		129. Name of state		130. Name of country		131. Name of continent		132. Name of world	
133. Name of city		134. Name of county		135. Name of state		136. Name of country		137. Name of continent		138. Name of world	
139. Name of city		140. Name of county		141. Name of state		142. Name of country		143. Name of continent		144. Name of world	
145. Name of city		146. Name of county		147. Name of state		148. Name of country		149. Name of continent		150. Name of world	
151. Name of city		152. Name of county		153. Name of state		154. Name of country		155. Name of continent		156. Name of world	
157. Name of city		158. Name of county		159. Name of state		160. Name of country		161. Name of continent		162. Name of world	
163. Name of city		164. Name of county		165. Name of state		166. Name of country		167. Name of continent		168. Name of world	
169. Name of city		170. Name of county		171. Name of state		172. Name of country		173. Name of continent		174. Name of world	
175. Name of city		176. Name of county		177. Name of state		178. Name of country		179. Name of continent		180. Name of world	
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187. Name of city		188. Name of county		189. Name of state		190. Name of country		191. Name of continent		192. Name of world	
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229. Name of city		230. Name of county		231. Name of state		232. Name of country		233. Name of continent		234. Name of world	
235. Name of city		236. Name of county		237. Name of state		238. Name of country		239. Name of continent		240. Name of world	
241. Name of city		242. Name of county		243. Name of state		244. Name of country		245. Name of continent		246. Name of world	
247. Name of city		248. Name of county		249. Name of state		250. Name of country		251. Name of continent		252. Name of world	
253. Name of city		254. Name of county		255. Name of state		256. Name of country		257. Name of continent		258. Name of world	
259. Name of city		260. Name of county		261. Name of state		262. Name of country		263. Name of continent		264. Name of world	
265. Name of city		266. Name of county		267. Name of state		268. Name of country		269. Name of continent		270. Name of world	
271. Name of city		272. Name of county		273. Name of state		274. Name of country		275. Name of continent		276. Name of world	
277. Name of city		278. Name of county		279. Name of state		280. Name of country		281. Name of continent		282. Name of world	
283. Name of city		284. Name of county		285. Name of state		286. Name of country		287. Name of continent		288. Name of world	
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295. Name of city		296. Name of county		297. Name of state		298. Name of country		299. Name of continent		300. Name of world	
301. Name of city		302. Name of county		303. Name of state		304. Name of country		305. Name of continent		306. Name of world	
307. Name of city		308. Name of county		309. Name of state		310. Name of country		311. Name of continent		312. Name of world	
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325. Name of city		326. Name of county		327. Name of state		328. Name of country		329. Name of continent		330. Name of world	
331. Name of city		332. Name of county		333. Name of state		334. Name of country		335. Name of continent		336. Name of world	
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343. Name of city		344. Name of county		345. Name of state		346. Name of country		347. Name of continent		348. Name of world	
349. Name of city		350. Name of county		351. Name of state		352. Name of country		353. Name of continent		354. Name of world	
355. Name of city		356. Name of county		357. Name of state		358. Name of country		359. Name of continent		360. Name of world	
361. Name of city		362. Name of county		363. Name of state		364. Name of country		365. Name of continent		366. Name of world	
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397. Name of city		398. Name of county		399. Name of state		400. Name of country		401. Name of continent		402. Name of world	
403. Name of city		404. Name of county		405. Name of state		406. Name of country		407. Name of continent		408. Name of world	
409. Name of city		410. Name of county		411. Name of state		412. Name of country		413. Name of continent		414. Name of world	
415. Name of city		416. Name of county		417. Name of state		418. Name of country		419. Name of continent		420. Name of world	
421. Name of city		422. Name of county		423. Name of state		424. Name of country		425. Name of continent		426. Name of world	
427. Name of city		428. Name of county		429. Name of state		430. Name of country		431. Name of continent		432. Name of world	
433. Name of city		434. Name of county		435. Name of state		436. Name of country		437. Name of continent		438. Name of world	
439. Name of city		440. Name of county		441. Name of state		442. Name of country		443. Name of continent		444. Name of world	
445. Name of city		446. Name of county		447. Name of state		448. Name of country		449. Name of continent		450. Name of world	
451. Name of city		452. Name of county		453. Name of state		454. Name of country		455. Name of continent		456. Name of world	
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463. Name of city		464. Name of county		465. Name of state		466. Name of country		467. Name of continent		468. Name of world	
469. Name of city		470. Name of county		471. Name of state		472. Name of country		473. Name of continent		474. Name of world	
475. Name of city		476. Name of county		477. Name of state		478. Name of country		479. Name of continent		480. Name of world	
481. Name of city		482. Name of county		483. Name of state		484. Name of country		485. Name of continent		486. Name of world	
487. Name of city		488. Name of county		489. Name of state		490. Name of country		491. Name of continent		492. Name of world	
493. Name of city		494. Name of county		495. Name of state		496. Name of country		497. Name of continent		498. Name of world	
499. Name of city		500. Name of county		501. Name of state		502. Name of country		503. Name of continent		504. Name of world	
505. Name of city		506. Name of county		507. Name of state		508. Name of country		509. Name of continent		510. Name of world	
511. Name of city		512. Name of county		513. Name of state		514. Name of country		515. Name of continent		516. Name of world	
517. Name of city		518. Name of county		519. Name of state		520. Name of country		521. Name of continent		522. Name of world	
523. Name of city		524. Name of county		525. Name of state		526. Name of country		527. Name of continent		528. Name of world	
529. Name of city		530. Name of county		531. Name of state		532.					

3088

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Aden</u> Middle <u>Ezekiel</u> Last <u>Bowen</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>19 60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 25, 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Agabus Bowen</u>				14. MOTHER'S MAIDEN NAME <u>Celeste Gibson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Wayne Bowen</u> Address <u>Huntingtown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension R.V.R.</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-8-1942</u> to <u>27 Mar 1960</u> , that I last saw the deceased alive on <u>27 Mar 1960</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Huntingtown, Maryland</u> DATE SIGNED <u>Mar. 27, 1960</u>							
ACTUAL SIGNATURE <u>G. J. Weems</u> M.D.							
PHYSICIAN'S NAME (Type) <u>G. J. Weems</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 29, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Huntingtown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home Owings md.</u> ADDRESS <u>  </u>				24a. REC'D BY REGISTRAR <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FORM 02-000000

100

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3089

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03066

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cabot</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u>		c. LENGTH OF STAY IN 1b <u>08x2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benedict</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cabot Co. H.</u>				d. STREET ADDRESS <u>08x2</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Joseph</u> Middle <u>Richard</u> Last <u>Cheseldine</u>				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>3/29/91</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTH PLACE (State or foreign country) <u>Md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Henry Cheseldine</u>			
14. MOTHER'S MAIDEN NAME <u>Emily Mapen</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>782.4</u>		17. INFORMANT <u>Mary A Cheseldine Benedict, md</u>		Address <u>Benedict, Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Ischemia</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Myocardial Infarction</u> (b) <u>Myocardial Infarction</u> (c) <u>Myocardial Infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been very sick for several days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year <u>14</u> <u>19</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Benedict</u>		(County) <u>Charles</u>		(State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H W Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H W Ward</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3/6/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>			
22d. LOCATION (City, town, or county) <u>Morganza</u>		(State) <u>Md.</u>		24a. REC'D BY REGISTRAR <u>W. Clarke Mattingley Leonardtown, Maryland</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		DATE <u>MAR 10 '60</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF VITALS		23. SIGNATURE OF DEATH		24. SIGNATURE OF DEATH	
25. SIGNATURE OF DEATH		26. SIGNATURE OF DEATH		27. SIGNATURE OF DEATH	
28. SIGNATURE OF DEATH		29. SIGNATURE OF DEATH		30. SIGNATURE OF DEATH	
31. SIGNATURE OF DEATH		32. SIGNATURE OF DEATH		33. SIGNATURE OF DEATH	
34. SIGNATURE OF DEATH		35. SIGNATURE OF DEATH		36. SIGNATURE OF DEATH	
37. SIGNATURE OF DEATH		38. SIGNATURE OF DEATH		39. SIGNATURE OF DEATH	
40. SIGNATURE OF DEATH		41. SIGNATURE OF DEATH		42. SIGNATURE OF DEATH	
43. SIGNATURE OF DEATH		44. SIGNATURE OF DEATH		45. SIGNATURE OF DEATH	
46. SIGNATURE OF DEATH		47. SIGNATURE OF DEATH		48. SIGNATURE OF DEATH	
49. SIGNATURE OF DEATH		50. SIGNATURE OF DEATH		51. SIGNATURE OF DEATH	
52. SIGNATURE OF DEATH		53. SIGNATURE OF DEATH		54. SIGNATURE OF DEATH	
55. SIGNATURE OF DEATH		56. SIGNATURE OF DEATH		57. SIGNATURE OF DEATH	
58. SIGNATURE OF DEATH		59. SIGNATURE OF DEATH		60. SIGNATURE OF DEATH	
61. SIGNATURE OF DEATH		62. SIGNATURE OF DEATH		63. SIGNATURE OF DEATH	
64. SIGNATURE OF DEATH		65. SIGNATURE OF DEATH		66. SIGNATURE OF DEATH	
67. SIGNATURE OF DEATH		68. SIGNATURE OF DEATH		69. SIGNATURE OF DEATH	
70. SIGNATURE OF DEATH		71. SIGNATURE OF DEATH		72. SIGNATURE OF DEATH	
73. SIGNATURE OF DEATH		74. SIGNATURE OF DEATH		75. SIGNATURE OF DEATH	
76. SIGNATURE OF DEATH		77. SIGNATURE OF DEATH		78. SIGNATURE OF DEATH	
79. SIGNATURE OF DEATH		80. SIGNATURE OF DEATH		81. SIGNATURE OF DEATH	
82. SIGNATURE OF DEATH		83. SIGNATURE OF DEATH		84. SIGNATURE OF DEATH	
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88. SIGNATURE OF DEATH		89. SIGNATURE OF DEATH		90. SIGNATURE OF DEATH	
91. SIGNATURE OF DEATH		92. SIGNATURE OF DEATH		93. SIGNATURE OF DEATH	
94. SIGNATURE OF DEATH		95. SIGNATURE OF DEATH		96. SIGNATURE OF DEATH	
97. SIGNATURE OF DEATH		98. SIGNATURE OF DEATH		99. SIGNATURE OF DEATH	
100. SIGNATURE OF DEATH		101. SIGNATURE OF DEATH		102. SIGNATURE OF DEATH	

RECEIVED  
BALTIMORE  
MAY 10 1968  
DEPARTMENT OF HEALTH  
VITALS SECTION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 5 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3090 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Whited</i> First <i>L</i> Middle <i>Bohy</i> Last 4. DATE OF DEATH Month <i>3</i> Day <i>9</i> Year <i>1960</i>		5. SEX <i>M</i> 6. COLOR OR RACE <i>E</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Feb 6 1959</i> 9. AGE (In years last birthday) yrs. <i>3</i> 10. IF UNDER 1 YEAR Months <i>3</i> Days <i>3</i> 11. IF UNDER 24 HRS. Hours <i>3</i> Min. <i>3</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Bohy</i>		14. MOTHER'S MAIDEN NAME <i>Esther Cleane Bohy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>475X</i>	
17. INFORMANT <i>Cleane Bohy</i> Address <i>Prince Frederick, Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Upper Respiratory Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>475X</i> (c) <i>Found dead in bed</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Found dead in bed</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <i>7 39 1960</i> 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i> 20f. City or town <i>Prince Frederick</i> (County) <i>Calvert</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i> EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>3/9/60</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3-11-60</i> 22b. DATE THEREOF <i>3-11-60</i> 22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive</i> 22d. LOCATION (City, town, or county) <i>Prince Frederick, Md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell</i> ADDRESS <i>Prince Frederick, Md</i>		24a. REC'D BY REGISTRAR <i>Artur S. Kraus</i> 24b. REGISTRAR'S SIGNATURE <i>Artur S. Kraus</i> DATE <i>MAR 14 '60</i>	

2069212XV4





# 1 1 064 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 064 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3991

## CERTIFICATE OF DEATH

03068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>22</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN IB <u>8 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cabot Co Hospital</u>		d. STREET ADDRESS <u>02X-2</u>	
3. NAME OF DECEASED (Type or print) <u>James Wesley</u> First Middle Last		4. DATE OF DEATH <u>3</u> <u>14</u> <u>1960</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Walter Wesley</u>		14. MOTHER'S MAIDEN NAME <u>Lillian A. Schubert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-28-8808</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3/14</u> , 19 <u>60</u> , to <u>3/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/14</u> , 19 <u>60</u> , and that death occurred at <u>1030 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H W Ward</u>		ADDRESS (Street, city or town, state) <u>Owings Md</u>	
PHYSICIAN'S NAME (Type) <u>H. W. WARD</u>		DATE SIGNED <u>3/14/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-17-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) <u>Friendship Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stutchins Funeral Home</u>		ADDRESS <u>Owings Md</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Knead</u>	



3092

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. H</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Summie L Espey</u> First Middle Last				4. DATE OF DEATH <u>3</u> Month <u>19</u> Day <u>1960</u> Year			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18-1871</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Md - Forestville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S A</u>	
13. FATHER'S NAME <u>John T. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Catherine E. Beane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u> <u>442X</u> DUE TO (b) <u>Cere</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tell 11/6/59 and fractured hip left</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) <u>Tell at home</u>					
20c. TIME OF INJURY Month, Day, Year <u>10</u> <u>11/6</u> <u>1959</u> Hour o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Ches. Beach</u> (County) <u>Calvert</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H W Wood</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/17/60</u>	
EXAMINER'S NAME (Type) <u>H W Wood</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>3-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Mem. Meth. Cemetery</u>		22d. LOCATION (City, town, or county) <u>Forestville</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros.</u> ADDRESS <u>10661- Good Hope Rd SE WASH DC</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1 and 2 must be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3093

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tracy</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tracy</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DRUCELLA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Druce, Ella</u> First <u>Ella</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH <u>3</u> Month <u>2</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Wm. T. Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Ann Weems</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary O. Johnson, Tracy, MD</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular finding during</u> <u>442X</u> DUE TO <u>eye</u> Conditions, if any, which gave rise to immediate cause (b) <u>eye</u> (c) stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had a pain in chest and died in a few min.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year <u>11/10</u> Hour a. m. <u>3/21</u> 19 <u>60</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Tracy</u> (County) <u>Calvert</u> (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. Ward</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/21/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-25-60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) <u>Tracy</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. E. Seewell, Prince Fred.</u>		24a. REC'D BY REGISTRAR <u>DATE 2 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03071

Reg. Dist. No.

3094

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Calvert</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>Franklin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklin</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co H</u>				d. STREET ADDRESS <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type and print) <u>Mary</u> First <u>Jones</u> Middle Last				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>23</u> Year <u>1960</u>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>8/18/83</u>			
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years less birthday) <u>76</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Post master</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Post office</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md</u>			
<b>13. FATHER'S NAME</b> <u>William W Whittington</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Olshin</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <u>WW Whittington</u>		<b>17. INFORMANT</b> <u>Balt 29/Md</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured hip 2/13/60</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input checked="" type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in her room at CCH Home Calvert Md</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>2</u> p. m. <u>2/3</u> 19 <u>60</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, hotel, office bldg., etc.) <u>H. Home</u>			
<b>20f. CITY OR TOWN</b> <u>Prince Frederick</u>		<b>20g. COUNTY</b> <u>Calvert</u>		<b>20h. STATE</b> <u>Md</u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>H W Ward</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>Witzke</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>3/23/60</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/28/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Baltimore 7, Md.</u>		<b>22e. STATE</b> <u>Md</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witzke Funeral Directors, 4101 Edmondson Ave</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE MAR 31 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kneass</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

528

3095  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabret</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Cabret</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Barstow</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabret County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Norman R. Whiter</i>		4. DATE OF DEATH <i>Mar. 1, 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 5, 1914</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self employed farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming - Painting</i>	9. AGE (In years last birthday) <i>45</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Cabret Co., Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Pracy Whiter</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ramsey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-16-4331</i>	
17. INFORMANT <i>Hagard Reid Whiter - Barstow, Ind</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carman's stroke</i> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause/lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been treated upon several occasions</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/27</i> , 19 <i>60</i> to <i>3/1</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2/29/60</i> , 19 <i>60</i> , and that death occurred at <i>8:20 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. W. Ward</i>		DATE SIGNED <i>3/1/60</i>	
PHYSICIAN'S NAME (Type) <i>H. W. WARD</i>		ADDRESS (Street, city or town, state) <i>Dwings, Ind</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 4, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Asbury Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Barstow - Cabret Co - Ind.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Tarkenton &amp; Son - Mutual, Ind.</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>MAR 3 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Tarkenton</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and filed as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3096

## CERTIFICATE OF DEATH

Reg. Dist. No.

64324

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Craig McDaniel Mason</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-60</u>
9. AGE (In years lost birthday) yrs. <u>2</u> Months <u>27</u> Days <u>27</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Winslow Mason</u>		14. MOTHER'S MAIDEN NAME <u>Urdina Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Winslow Mason, Island Creek</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 Jan</u> , 19 <u>60</u> , to <u>30 Nov</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>30 Nov</u> , 19 <u>60</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. _____	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-1-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brooks Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u>		ADDRESS <u>Prince Frederick</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

DATE

1900

PLACE

1. PLACE OF DEATH

2. TIME OF DEATH

3. CAUSE OF DEATH

4. PLACE OF BIRTH

5. AGE

6. SEX

7. OCCUPATION

8. MARITAL STATUS

9. EDUCATION

10. RELIGION

11. COLOR

12. RACE

13. BUILD

14. COMPLEXION

15. HAIR

16. EYES

17. MOUTH

18. NOSE

19. EARS

20. TEETH

21. SKIN

22. FINGERS

23. TOES

24. NAILS

25. SCARS

26. TATTOOS

27. OTHER

28. SIGNATURE

29. ADDRESS

30. CITY

31. STATE

32. COUNTRY

33. DATE

34. TIME

35. PLACE

1. PLACE OF DEATH

2. TIME OF DEATH

3. CAUSE OF DEATH

4. PLACE OF BIRTH

5. AGE

6. SEX

7. OCCUPATION

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21. SKIN

22. FINGERS

23. TOES

24. NAILS

25. SCARS

26. TATTOOS

27. OTHER

28. SIGNATURE

29. ADDRESS

30. CITY

1. PLACE OF DEATH

2. TIME OF DEATH

3. CAUSE OF DEATH

4. PLACE OF BIRTH

5. AGE

6. SEX

7. OCCUPATION

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24. NAILS

25. SCARS

26. TATTOOS

27. OTHER

28. SIGNATURE

29. ADDRESS

30. CITY

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6. SEX

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25. SCARS

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27. OTHER

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29. ADDRESS

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5. AGE

6. SEX

7. OCCUPATION

8. MARITAL STATUS

9. EDUCATION

10. RELIGION

11. COLOR

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13. BUILD

14. COMPLEXION

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22. FINGERS

23. TOES

24. NAILS

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29. ADDRESS

30. CITY

1. PLACE OF DEATH

2. TIME OF DEATH

3. CAUSE OF DEATH

4. PLACE OF BIRTH

5. AGE

6. SEX

7. OCCUPATION

8. MARITAL STATUS

9. EDUCATION

10. RELIGION

11. COLOR

12. RACE

13. BUILD

14. COMPLEXION

15. HAIR

03073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If no information, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION <u>Calvert County Hospital</u>		d. STREET ADDRESS <u>Island Creek</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M.</u> Last <u>PARDOE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1888</u>
9. AGE (in years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph F. Himmer</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Schweitzer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Lawrence Pardoe, Island Creek Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1955</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA of BREAST 1946</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 1954</u> , to <u>MARCH 9, 1960</u> , that I last saw the deceased alive on <u>MARCH 8, 1960</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page Jett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Prince Frederick, Md.</u>	
PHYSICIAN'S NAME (Type) <u>PAGE JETT</u>		<u>PRINCE FREDERICK MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 13, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Natural Memorial Co.</u>	22d. LOCATION (City, town, or county) (State) <u>Island Creek Calvert Co, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Hartman</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 14 '60</u>	
ADDRESS <u>Island Creek, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03074

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cabert</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mutual</u> c. LENGTH OF STAY IN lb <u>1 yr - 1 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution/Residence before admission) a. STATE <u>Tenn</u> b. COUNTY <u>Hawken</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchill</u> d. STREET ADDRESS <u>04X-1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>Betty Martha Lee Warren</u> First Middle Last				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>19</u> Year <u>1960</u>													
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 16, 1905</u>		<b>9. AGE</b> (In years last birthday) <u>54</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Tenn</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Tenn</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>					
<b>13. FATHER'S NAME</b> <u>Samuel Thompson</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Elyzabeth Carr</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>						<b>16. SOCIAL SECURITY NO.</b> <u>No</u>						<b>17. INFORMANT</b> <u>Mrs. Warren, Mutual Rd</u> Address _____					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>782.4</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____												INTERVAL BETWEEN ONSET AND DEATH _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was reading clock, and was found dead on sofa</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>4:30</u> am. <u>3/19</u> 19 <u>60</u> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Mutual Cabert</u> (County) <u>Tenn</u> (State) <u>MD</u>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <u>H. W. Ward</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>3/19/60</u>					
<b>EXAMINER'S NAME (Type)</b> <u>H. W. WARD</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>				<b>22b. DATE THEREOF</b> <u>Mar 20, 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Buffalo Cemetery</u>				<b>22d. LOCATION</b> (City, town or county) <u>Bluff City</u> (State) <u>Tenn.</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>A. A. Harkness &amp; Son - Mutual, Tenn</u>						<b>24a. REC'D BY REGISTRAR</b> <u>William S. Hume</u>				<b>24b. REGISTRAR'S SIGNATURE</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03075

3099

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>4 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>HAMILTON</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1874</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>30</b> Days <b>19</b> Hours <b>60</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Millard Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Emma Essex</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Daisy Smack</b>		Address <b>Huntingtown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-10-1948</b> to <b>3-20-1960</b> , that I last saw the deceased alive on <b>3-18-1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Huntingtown, Maryland</b> DATE SIGNED <b>3/21/60</b>			
ACTUAL SIGNATURE <b>G. J. Weems</b>		M.D. <b>Huntingtown, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>G. J. Weems</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-23-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Plum Point Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bulchins Funeral Home Owings Ind.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>MAR 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krawe</b>	

# CERTIFICATE OF DEATH

3-28

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH (as certified by the attending physician)

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DETAILED STATEMENT OF CAUSE OF DEATH (as certified by the attending physician)

DATE OF DEATH

PLACE OF DEATH

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH (as certified by the attending physician)

PLACE OF BIRTH

DETAILED STATEMENT OF CAUSE OF DEATH (as certified by the attending physician)

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